Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual + Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsms.com or by calling 1-800-222-8046. You may also contact the Department of Personnel Management/Insurance at 601-960-1051 or 601-960-2288.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$400 for Individuals. \$1,200 for Families. Doesn't apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other deductibles for specific services?	Yes. <b>\$50</b> for prescriptions. There are no other specific <b>deductibles</b> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. <b>\$5,000</b> for Individuals.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance-billed charges, co-payments, deductibles, outpatient treatment for mental/behavioral health and substance use disorders, premiums, TMJ benefits, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	Yes. <b>\$2 Million.</b>	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See <u>www.bcbsms.com</u> or call 1-800-222-8046 for a list of Network Providers	If you use an in-network doctor or other healthcare <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- <u>Co-payments</u> are fixed dollar amounts (for example, \$15) you pay for covered healthcare, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use Network Providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Primary care visit to treat an injury or illness	\$20 /visit	25% Co-insurance	Co-pay does not apply to any other services rendered in the provider's office or to Physician Assistants or Nurse Midwives.
	Specialist visit	\$30 /visit	25% Co-insurance	Co-pay does not apply to any other services rendered in the provider's office.
If you visit a healthcare <u>provider's</u> office or clinic	Other practitioner office visit	\$30 /visit to Podiatrist; 25% Co- insurance for other Allied Providers	25% Co-insurance	Co-pay does not apply to any other services rendered in the provider's office. Physical medicine subject to limit of 20 visits per year. Routine vision and podiatry are not covered. Chiropractic Care has a \$75 maximum allowable charge and is limited to 12 visits per year.
	Preventive care/screening/immunization	\$20/visit; No charge for Mammography, PSA Test, Childhood Immunization and Colonoscopy.	Not covered	Services must be rendered by a Primary Care Provider in that Provider's clinical setting and according to the Preventive Health Services Age and Gender Guidelines for the covered services. Age and visit limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	25% Co-insurance	25% Co-insurance	none
ii you nave a test	Imaging (CT/PET scans, MRIs)	25% Co-insurance	25% Co-insurance	none

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic	\$10/prescription	\$20/prescription	
More information about	Preferred Brand	\$25/prescription	\$50/prescription	Limited to a 30 day supply
<u>coverage</u> is available at www.bcbsms.com.	Non-Preferred Brand	\$50/prescription	\$100/prescription	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	25% Co-insurance	35% Co-insurance	none
surgery	Physician/surgeon fees	25% Co-insurance	25% Co-insurance	none
If you need immediate medical attention	Emergency room services	25% Co-insurance	25% Co-insurance	Your cost if you use a Non-Network Provider for non-emergency services will be 35%.
	Emergency medical transportation	25% Co-insurance	25% Co-insurance	none
	Urgent care	\$20/primary care visit; \$30/specialist visit	25% Co-insurance	Co-pay does not apply to any other services rendered in the provider's office or to Physician Assistants or Nurse Midwives.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Co-insurance	35% Co-insurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from nonnetwork provider. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance.
	Physician/surgeon fee	25% Co-insurance	25% Co-insurance	none

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% Co-insurance	50% Co-insurance	Prior authorization required. Physician office visits and outpatient hospital visits limited to a combined 52 visits per year. When services are pre-certified and managed by the employee assistance program coordinator, your cost will be 25% Co-insurance.
	Mental/Behavioral health inpatient services	25% Co-insurance	Inpatient: 25% Co- insurance. Partial hospitalization: 35% Co-insurance.	Prior authorization required. Limited to 30 inpatient days per year. Partial hospitalization limited to 60 days per year. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient and partial hospitalization services.
	Substance use disorder outpatient services	50% Co-insurance	50% Co-insurance	Prior authorization required. Physician office visits and outpatient hospital visits limited to a combined 52 visits per year. When services are pre-certified and managed by the employee assistance program coordinator, your cost will be 25% Co-insurance.
	Substance use disorder inpatient services	25% Co-insurance	Inpatient: 25% Co- insurance. Partial hospitalization: 35% Co-insurance.	Prior authorization required. Limited to 30 inpatient days per year. Partial hospitalization limited to 60 days per year. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient and partial hospitalization services.
If you are pregnant	Prenatal and postnatal care	\$20 /visit	25% Co-insurance	Maternity coverage is not available for
	Delivery and all inpatient services	25% Co-insurance	35% Co-insurance	dependent children.

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	Home health care	25% Co-insurance	25% Co-insurance	Limited to 30 days per year.
If you need help recovering or have other special health needs	Rehabilitation services	25% Co-insurance	Inpatient rehabilitation: 35% Co-insurance; Speech, Physical and Occupational Therapy: 25% Co- insurance	Inpatient Rehabilitation limited to 30 days per year by Network Provider. After out-of-pocket is met, your cost to use a Non-Network Provider is 10% Co-insurance for inpatient rehabilitation. Physical Medicine limited to 20 outpatient visits per year. Outpatient Cardiac Rehab limited to 36 visits per year and must be rendered by Network Provider. Speech Therapy limited to 20 outpatient visits per year and not available for learning or developmental disabilities.
	Habilitation services	Not covered	Not covered	Habilitation services are not available.
	Skilled nursing care	Not covered	Not covered	none
	Durable medical equipment	25% Co-insurance	35% Co-insurance	none
	Hospice service	25% Co-insurance	25% Co-insurance	30 day lifetime limitation
	Eye exam	Not covered	Not covered	
If your child needs dental or eye care	Glasses	Not covered	Not covered	Routine dental and eye care are not available.
	Dental check-up	Not covered	Not covered	

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#### **Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Habilitation Services

- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Chiropractic Care

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan administrator at 601-960-1051. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <a href="https://www.dol.gov/ebsa">www.dol.gov/ebsa</a>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>.

### **Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: Blue Cross & Blue Shield of Mississippi at 1-800-222-8046 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa</u>.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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# **About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,680
- Patient pays \$1,860

#### Sample care costs:

Total	\$7,540
Vaccines, other preventive	\$40
Radiology	\$200
Prescriptions	\$200
Laboratory tests	\$500
Anesthesia	\$900
Hospital charges (baby)	\$900
Routine obstetric care	\$2,100
Hospital charges (mother)	\$2,700

#### Patient nave:

r aliciil pays.	
Deductibles	\$420
Co-pays	\$20
Coinsurance	\$1,270
Limits or exclusions	\$150
Total	\$1,860

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,400

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

#### Patient navs:

\$450
\$600
\$270
\$80
\$1,400

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**Questions and answers about the Coverage Examples:** 

# What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-Network <u>Providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

# Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

# Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

# Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

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# Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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